STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	04/26/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STERLING HOUSE OF MICHIGAN CITY	1400 E COOLSPRING AVE MICH CITY, IN46360

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R0000	This visit was for the investigation of Complaint IN00088424. Complaint IN00088424- Substantiated. State residential deficiencies related to the allegations are cited at R0036, R0145, R0217, and R0349. Survey dates: April 25 and 26, 2011 Facility number: 0101610 Provider number: 010610 AIM number: N/A Survey team: Janet Adams, RN, TC Kathleen Vargas, RN (April 26, 2011) Census bed type: Residential: 58 Total: 58 Census payor type: Other: 58 Total: 58 Sample: 7 These State Residential findings are in accordance with 410 IAC 16.2-5.	R0000	The following is the Plan of Correction for the Clare Bridge of Michigan City in regards to the Statement of Deficiencies for the complaint survey completed on 4-26-2011. This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvement to satisfy that objective.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Quality review completed 4-27-11 Cathy Emswiller RN			
R0036	(k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has noticed: (1) a significant decline in the resident ' s physical, mental, or psychosocial status; or (2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment. Based on record review and interview, the facility failed to notify the physician and the s legal representative of the repeated medication refusals for 1 of 7 residents reviewed of medication refusal in the sample of 7. (Resident #D) The facility policy titled "Medications & Treatments-Refusal" was reviewed on 4/25/11 at 10:30 a.m. The policy was provided by the facility Administrator. There was a revised date of August 2006 on the policy. The policy indicated if an unlicensed associate is administering the medications they are to notify the Nurse and Executive Director of the refusals. The policy also indicated staff were to circle the medication on the Medication Administration Record and document the refusal in the Resident Log. The Nurse or designee were to contact the physician to report the refusal as soon as possible.	R0036	**R 0036 Resident Rights** ***What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?*** · Resident D: Physician was notified of continued refusals to take the anti-psychotic medication. He had given the order to discontinue that medication prior to the survey. Co-guardians were notified. ***How will the facility identify other residents with the potential to be affected by the same alleged deficient practice and what corrective action will be taken?*** · Health and Wellness Director for the Clare Bridge/Designee will be responsible for conducting an inservice for nurses regarding the existing guideline for handling and documentation of resident medication refusals, along with physician and responsible party	05/24/2011

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	The record for Resident #D was reviewed on 4/25/11 at 10:15 a.m. The resident's diagnoses included, but were not limited to dementia, psychotic disorder, and osteoporosis. A Physician's order was written on 11/26/10 for the resident to receive Zyprexia (an anti psychotic medication) 2.5 milligrams once a day at 5:00 p.m. A Physician's order was written on 3/3/11 to discontinue the Zyprexia. Review of the 12/2010 Medication Administration Record indicated the Zyprexia was circled as not given 12/2/10 through 12/13.10, and 12/16/10 through 12/29/10. Review of the 1/2011 Medication Administration Record indicated the Zyprexia was circled as not given on 1/1/11 through 1/11/11, 1/13/11 through 1/15/11, and 1/17/11 through 1/29/11. The entries on 1/12/11 and 1/16/11 were blank. Review of the 2/2011 Medication Administration Record indicated the Zyprexia was circled as not given 2/1/11 through 2/28/11. The 12/2010, 1/2011, and 2/2011 Resident		notification requirements. **What measures will be put in place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur?** · MAR audits will be conducted daily by the nurse or QMA on each shift to determine number of medication refusals. If a medication is refused three or more days in a row, the Health and Wellness Director/Executive Director/Designee will be notified. · Nurse will then be responsible for completion of MD and responsible party notifications, and will also be responsible for documenting their actions in the clinical record. **How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put in place?** · The Health and Wellness Director/Designee will be responsible for conducting Medication Administration Record audits twice weekly to monitor for compliance with the above process. · Corrective action notices will be issued to nurses in the event non-compliance is noted, and the Health and Wellness Director/Designee will then complete notifications where indicated. The Executive Director and Health and Wellness Director will review results of the audits monthly to determine if	

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	Log notes were reviewed. There was no documentation of the Physician being notified of the resident's repeated refusals of the medications. There was documentation of a family member being notified of the refusal of the medication on the 12/3/10, 12/6/10, 12/8/10, 12/19/10, 1/11/11, 1/27/11, 2/15/11, 2/22/11, 2/25/11, and 2/28/11. There was documentation of the resident's legal representative being notified of the resident's ongoing refusal of the Zyprexia. When interviewed on 4/25/11 at 1:15 p.m., the Wellness Director indicated there was no documentation of the physician being notified of the resident's continual refusal of the Zyprexia for the above months. The Wellness Director also indicated the family should have been notified of the continuous refusals. This State Residential Finding relates to Complaint IN00088424.		additional action is required. ***By what date will these systemic changes be implemented?*** · 5-24-11	

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R0145	(b) The facility shall maintain equipment and supplies in a safe and operational condition and in sufficient quantity to meet the needs of the residents. Based on observation, record review, and interview, the facility failed to provide safe conditions to meet the needs of 1 of 1 residents reviewed for safe bathing in the Memory Care unit in the sample of 7. (Resident #D) Findings include: Observations on 4/25/11 at 3:25 p.m., 4/25/11 at 4:10 p.m., and 4/26/11 at 7:50 a.m., indicated the door to the common bathroom was unlocked. There was a walk in type tub in the bathroom. There were no residents in the bathroom at the above times. There were no staff members in view of the bathroom at the above times. There was a hand written sign on paper that was taped to the bathroom door just above the door handle. The sign indicated the door was not to be locked. The record for Resident #D was reviewed on 4/25/11 at 10:15 a.m. The resident's diagnoses included, but were not limited to, dementia, osteoporosis, osteoarthritis, and high blood pressure. An entry in the 3/11 Resident Log notes	R0145	**R 0145 Safety and Sanitation** ***What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?*** · Resident D: Review of clinical record indicates no falls or other incidents have occurred in the past year for this resident related to the independent use of the tub room for bathing. In addition, the guardians had not previously contracted for assistance with bathing, as resident is able to perform this task independently at the current time, and the community will continue to encourage resident to remain active and at her highest practicable level of independence · Resident's Personal Service Plan will be updated to include the daughter-in-law's request for additional supervision and oversight of the resident's use of tub room. Personal service plan will be reviewed with the guardians to inform them of additional service charges required for 7 day per week supervision of bathing. They will then be free to choose a 1:1 outside caregiver for use during the resident's selected evening bath times vs. contracting Clare Bridge associates to provide this care 7 days per week. Once the	05/24/2011

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	made on 3/28/11 at 1:45 p.m., indicated the resident's family member called the facility and informed the staff the resident told her she has a hard time with the shower door. The family member indicated the resident had fallen in the past. The facility Administrator and the Wellness Director were interviewed on 4/25/11 at 1:15 p.m. The Administrator indicated the Maintenance Director did give a key to the resident. The Administrator indicated the resident had the key for less then 24 hours. The Wellness Director and the Administrator indicated the bathroom had been unlocked and the protocol now was to leave the room locked and the resident would ask staff to unlock the door. This State Residential Finding relates to Complaint IN00088424.		co-guardians agree on which method they would prefer, the Personal Service Plan will then be signed by one or both co-guardians to indicate their agreement with the additional services. · The Ombudsman will be contacted to intervene should the guardians continue to be in disagreement with the personal service needs of the resident. ***How will the facility identify other residents with the potential to be affected by the same alleged deficient practice and what corrective action will be taken?*** · It is the Clare Bridge practice to leave rest rooms and shower rooms with toilets unlocked when not in use. The rationale is that Clare Bridge chooses to provide a home-like environment for residents with memory care needs, and also to allow residents to function at their highest practicable level and independently toilet themselves without having to request an associate to unlock a door. **What measures will be put in place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur?** · The Health and Wellness Director /Designee will conduct an inservice for caregivers informing them of safety practices for the bathroom areas.. · Care Profiles and assignment sheets for all residents will be reviewed by the	

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			Health and Wellness Director/Designee for accuracy, and any revisions will be added at that time. **How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put in place?** · The Clare Bridge will continue to monitor potential for safety issues on an individual basis, during the Collaborative Care meeting twice monthly and through daily review of the 24 hour shift report for incidents related to safety. · The Executive Director and Health and Wellness Director will confer two times weekly to review all incidents and make recommendations for any changes necessary on the Personal Service Plan of any resident. . **By what date will these systemic changes be implemented?** · 5-24-11	

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R0217	(e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.			
	Based on record review and interview the facility failed to ensure Service Plans were revised related to refusal of psychotropic medications for 1 of 1 resident in the sample of 7 who were reviewed for Service Plan revision. (Resident #D) Findings include:	R0217	**R 0217 Evaluation** **What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?** · Resident D: The one medication that this resident had been refusing to take (the anti-psychotic medication, Zyprexa) was discontinued by the physician on 3-30-11, prior to the date of this	05/24/2011

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	The record for Resident #D was reviewed on 4/25/11 at 10:15 a.m. The resident's diagnoses included, but were not limited to dementia, psychotic disorder, and osteoporosis. The facility policy titled " Personal Service Plan" was reviewed on 4/25/11 at 10:30 a.m. The policy was provided by the Administrator. There was a revised date of January 2009 on the policy. The policy indicated the Service Plans were to be reviewed by the care team and the resident/legally responsible party. The Service Plans were to reviewed and revised as necessary following a change in the condition of the resident that results in altered care needs over a period of greater than two weeks. A Physician's order was written on 11/26/10 for the resident to receive Zyprexia (an anti psychotic medication) 2.5 milligrams once a day at 5:00 p.m. A Physician's order was written on 3/3/11 to discontinue the Zyprexia. Review of the 12/2010 Medication Administration Record indicated the Zyprexia was circled as not given 12/2/10 through 12/13/10, and 12/16/10 through 12/29/10.		survey, therefore there are no longer any medication refusals occurring related to this resident, so the Personal Service assessment regarding refusals is currently accurate in stating there are no medication refusals. · Physician orders will be implemented and any changes or updates related to the Personal Service Plan for this resident will be discussed with the co-guardians in an on-going manner. ***How will the facility identify other residents with the potential to be affected by the same alleged deficient practice and what corrective action will be taken?*** · The Health and Wellness Director will review Medication Administration Records twice weekly to determine those residents with medication refusals. · Residents who elect their right to refuse medications will have their Personal Service Assessments and Personal Service Plans updated to reflect the need for additional attention related to medication refusals. · The responsible parties will be notified by the Health and Wellness Director/Designee of any additions or changes to the Personal Service Plan. .	

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	Review of the 1/2011 Medication Administration Record indicated the Zyprexia was circled as not given on 1/1/11 through 1/11/11, 1/13/11 through 1/15/11, and 1/17/11 through 1/29/11. The entries on 1/12/11 and 1/16/11 were blank. Review of the 2/2011 Medication Administration Record indicated the Zyprexia was circled as not given 2/1/11 through 2/28/11. A Personal Service Plan was completed on 1/6/2011. The Service Plan was signed by the resident's legal representative and a facility representative on 1/27/11. The Service Plan included Behavior Management as the resident demonstrates anxious, disruptive, or obsessive behaviors requiring additional attention. The "comments" section for Behavior Management section indicated the resident has obsessive behaviors at times related to finances and guardianship and has exhibited some anxious behaviors. There was no documentation or update on the Service Plan related to the residents ongoing refusal of the psychotropic medication. When interviewed on 4/25/11 at 1:15 p.m., the Wellness Director indicated the current 1/6/11 Service Plan did not		**How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put in place?** · Medication Administration audit findings will be reviewed by the Health and Wellness Director/Designee with findings reported to the physician and responsible parties. · The Health and Wellness Director will document refusals on the PSP and the Executive Director will review resident medication refusals as part of the Collaborative Care Meeting process which occurs 2 x monthly and is ongoing. **By what date will these systemic changes be implemented?** · 5-24-11	

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	address the resident's refusal of the antipsychotic medications. This State Residential Finding relates to Complaint IN00088424.			
R0349	(a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on record review and interview, the facility failed to ensure information related to residents resuscitation status was accurate and complete for 2 of 7 residents reviewed for code (resuscitation) status in the sample of 7. (Residents #B and #D) Findings include: 1. The record for Resident #D was reviewed on 4/25/11 at 10:15 a.m. The resident was admitted to the facility in 2/2008. Review of the 3/11 and 4/11 Physician Order Statements indicted the resident's code status was "full code." A 1/6/11 Personal Service Plan was signed by the facility staff and the resident's legal guardian on 1/27/11. The Personal Service Plan indicated there was DNR (Do Not Resuscitate) on file. A "Health Care Request" form indicated the	R0349	**R 0349 Clinical records** ***What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?*** · Resident B and D: The community will implement the State of Indiana's "Out of Hospital Do Not Resuscitate form". The responsible party and physician will be asked to sign the form, along with the physician. Those choosing DNR orders will have this information kept in their clinical record as well as added to the Physician Order Sheet. If a resident makes no choice concerning advance directives or chooses Full Code status, then the Health Care Request form will be utilized and will be available in the	05/24/2011

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	residents legal representative checked the following: "Do not wish to have Cardio-pulmonary resuscitation performed as a potentially life-saving measure." The form was signed by the resident legal guardian on 2/24/11. When interviewed on 4/26/11 at 10:55 a.m., LPN #1 indicated she was assigned to care for the resident. The LPN indicated the code status of the resident is to be listed on Physician Orders and the Health Care form. The LPN also indicated the code status of all the residents is written on the assignment sheet she has. The LPN's current assignment sheet was review at this time. "Full Code" was typed next to Resident #D's name. When interviewed on 4/25/11 at 1:15 p.m., the Wellness Director indicated the code status should be accurate. 2. The record for Resident #B was reviewed on 4/26/11 at 10:35 a.m. The resident's diagnoses included, but were not limited to, depression, moderate/severe dementia, asthma, and degenerative arthritis. A "Health Care Request" form indicated the residents' legal representative checked the section "Do not wish to have Cardio-pulmonary resuscitation performed as a potentially life-saving measure." The legal representative signed the form on 8/9/10. The resident's physician signed the form on 11/17/10. The "Code Status" section on the 4/11 and the 3/11 Physician Order Statements was blank. When interviewed on 4/25/11 at 1:15 p.m., the Wellness Director indicated the code status should be accurate.		clinical record and added to the Physician Order sheet. ***How will the facility identify other residents with the potential to be affected by the same alleged deficient practice and what corrective action will be taken?*** · Other residents have the potential to be affected by the alleged deficient practice. · Chart audits by the HWD/Designee will occur to determine existing orders vs. signed documentation. · For those who request DNR orders, care conferences will be held with responsible parties and Health and Wellness Director / Designee will obtain signatures on the above new forms. · Code status orders will be transcribed onto the Physician Order sheets by the HWD/Designees. **What measures will be put in place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur?** · Nurses will be re-educated on the use of the new "Out of Hospital DNR " form, as well as regarding the use of the current Health Care Request form for those choosing Full Code (CPR requested) status.	

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	This State Residential Finding relates to Complaint IN00088424.		**How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put in place?** · Code status orders vs. Health Care Requests/DNR requests will be audited by the HWD monthly to ensure the pharmacy provider has added the new orders to the Physician Order sheets. In the event of a discrepancy, the clinical record will be reviewed and corrections, if any, made to the Physician Order sheet to reflect the most current order. . **By what date will these systemic changes be implemented?** · 5-24-11	